Presumptive Medical Disability Team Referral

Initial Referral: ☐ No ☐ Yes		**Date of MS or GA Application:**	
Type of Referral: ☐ Current GA	☐ Medicaid Only	☐ GA & Medicaid	☐ GA RN
PMDD Questionnaire – HIPAA Release Due Date:			
PMDD Questionnaire Attached: ☐ No ☐ Yes		**HIPAA Release Attached:** ☐ No ☐ Yes	

A. Applicant Information:

Last Name:		First Name:	
Address:		City:	
State:	Zip:	County:	Sex:
Phone #:	Alt Phone #:		DOB:
SSN:	Case #:	Client ID:	

B. List Third Party Involvement (CMHC, CDDO etc):

Does the applicant have a medical representative or guardian/conservator?	☐ No	☐ Unknown	☐ Yes (name & contact info listed below)
Last Name:		First Name:	
Address:		City:	State:
Zip Code:	Phone #:	Alt. Phone #:	
Does the applicant have legal or Social Security representation?	☐ No	☐ Yes (name & contact info listed below)	
Last Name:		First Name:	
Organization:		Phone #:	

C. Describe observations by staff regarding physical or mental limitations (e.g. trouble walking, confusion, hard of hearing).

D. List the disabling conditions/impairments:

E. Has the applicant applied for Social Security Disability?		☐ No	☐ Yes
If yes, date of application:	**Outcome:**	☐ Denied	☐ Pending
Has the applicant appealed or reapplied?		☐ No	☐ Yes
Does the applicant have a new condition that Social Security did not previously review?		☐ No	☐ Yes
Or has the original condition become worse?		☐ No	☐ Yes

Eligibility Worker: **Date:**